Child Fatality Review Committee Annual Report 2021

Department of Health and Human Services
Division of Public Health Services

December 15, 2021

Acknowledgement

We would like to take a moment to acknowledge the hard work and dedication that every participant contributes to the efforts of child fatality review. Reviewing circumstances surrounding any death is never easy and it is that much more difficult when it is a child. Through your commitment to this program, recommendations are created in an effort to prevent similar unfortunate circumstances from occurring again.

Thank you.

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Letter from Child Fatality Review Commission Co-Chairs

Dear Friends of New Hampshire Children,

The New Hampshire Child Fatality Review Committee (CFRC) has begun its 25th year of reviewing fatalities of New Hampshire children. The work of the committee is to ensure the health and safety of the children of New Hampshire and to reduce the number of preventable child deaths.

The following is the Committee's annual report, covering the work of the committee for the calendar year 2021. The report summarizes data from the 5-year period 2016 – 2020, along with single year (2020) data when possible. Because there are relatively few child fatalities in New Hampshire on a yearly basis, single year data can fluctuate greatly from year to year; analysis in 5-year aggregations is more stable.

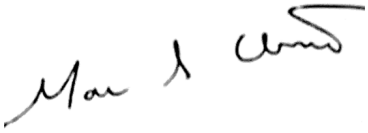
The CFRC was established by an Executive Order of then Governor Judd Gregg under which it functioned for over 20 years. In the 2018/2019 timeframe it became clear that this Executive Order was not sufficient for the Committee to function efficiently. Legislation (Senate Bill 118; subsequently House Bill 1245) was proposed to establish a new committee. This legislation, signed into law by Governor Christopher Sununu in August of 2019, better clarified the membership, role, purview, protections of the committee and placed the Sudden Unexplained Infant Death (SUID) and the Sudden Death in Youth (SDY) committees as sub-committees under the CFRC with the same protections and responsibilities

As the new committee began its work in the fall of 2019, members were appointed and oriented to the functions of the committee. Case reviews and the creation of recommendations based on those reviews occurred during committee meetings in 2019 and into 2020. Because of the impact of COVID-19 pandemic, the committee met virtually from the spring of 2020 until the spring of 2021. The Committee currently meets in person.

This report includes data describing the status of child fatalities in New Hampshire, as well as a set of recommendations stemming from the thoughtful review of the committee, focused on two specific causes of death: overdose and motor vehicle deaths. The committee would like to recognize that each child fatality impacts a community that suffered a loss of a child. The committee respects those impacted by these deaths. We hope that the difficult work of reviewing cases to find recommendations to possibly prevent future tragedies is valuable.

In recognition of this commitment and dedication, it is with great pride that as Co-Chairs, we present our 18th annual report to: Christopher T. Sununu, Governor of the State of New Hampshire; New Hampshire State Senate President Chuck Morse; Speaker of the New Hampshire House of Representatives, Sherman Packard; the Health and Human Services Oversight Committee; and the people of the State of New Hampshire.

Josephine Porter, Co-Chair



Marc Clement, PhD, Co-Chair

Executive Summary

This report reflects the work of the New Hampshire Child Fatality Committee (CFRC) during the calendar year 2021. The work of the committee and the purpose of the recommendations resulting from our reviews aim to reduce preventable child fatalities in New Hampshire. During 2021, the Committee held six review meetings and reviewed eight cases, which included four drug related fatalities and four motor vehicle accidents.

Purpose

The Department of Health and Human Services (DHHS), in conjunction with the Office of the Chief Medical Examiner (OCME) and in accordance with RSA 611-B, has established a child fatality review committee to conduct comprehensive, multidisciplinary reviews of preventable infant, child, and youth deaths in New Hampshire. The purpose of the committee is to identify factors associated with these deaths and to make recommendations for system changes to improve services for infants, children, and youth.

A preventable death is one in which, by retrospective analysis, it is determined that a reasonable intervention (e.g. medical, educational, social, legal or psychological) might have prevented the death. “Reasonable” is defined as taking into consideration the conditions, circumstances, or resources available.

The committee recognizes that the responsibility for responding to and preventing child fatalities lies with the community, not with any single agency or entity. The CFRC reviews the deaths to decrease the risks for children and provide solutions in the form recommendations to key stakeholders with the intention of reducing future fatalities. The CFRC is not an investigative body and is not a mechanism to assign fault to an agency or individual. It is a forum for sharing information essential to the improvement of a community’s response to a child fatality. The information on meetings and other information about the committee is available at: https://www.dhhs.nh.gov/dphs/bchs/mch/cfrc/index.htm

Child Fatality Data Report

Data presented in this report represent state-level trends from death certificate data among children from birth through the age of 21 who were residents of the state of New Hampshire. Rates for the United States are included for comparison purposes; United States rates are from the Centers for Disease Control and Prevention (CDC), National Center for Health Statistics, from the CDC WONDER online database.

Data Definitions

All deaths are classified according to cause and manner of death. There are many complexities involved in determining cause and manner of death, beginning with the definition of each term. **Cause of death** refers to the disease process or injury which set into motion the series of events which eventually lead to death. **Manner of death** refers to the circumstances under which death occurred. In New Hampshire, deaths are classified on the death certificate as resulting from one of the following manners of death: natural (due to underlying medical conditions, unrelated to any external factors), accident (injury or poisoning without intent to cause harm or death), suicide, homicide, (suicide or homicide are cases with confirmed intent to cause death), or could not be determined (insufficient information is available to determine a manner of death). When the manner of death is listed as "pending," further investigative, historical, or laboratory information is expected before a determination of manner of death can be made.

For this report, death data is broken into two classifications of death: **natural causes** and **injuries**. Death by natural causes is a strictly defined term utilized when the cause of death is due exclusively to disease with no contribution by any injury or other exogenous factor. It encompasses, but is not limited to, diseases of the heart, malignant neoplasms (i.e. cancer), and conditions originating in the perinatal period (such as low birth weight and prematurity). The second category of death is injury which refers to death from damage done to the structure or function of the body caused by an outside agent or force, which may be physical (as in a fall) or chemical (as in a burn or poisoning). Injury deaths are further classified as **unintentional** (such as in accidental drowning) or **intentional** (suicide or homicide).

For this report, we have not disaggregated data by race and ethnicity due to small numbers. Counts of 10 or fewer events may be due to chance alone and do not produce reliable statistics. One should use caution when interpreting small numbers and the percentages derived from them.

General Overview

Approximately half of the deaths (52%) in New Hampshire children from birth through age twenty-one were due to natural causes over the last 5 year period, 2016-2020 (Table 1). This was also the case for calendar year 2020 (56.3%, Table 1).

Table 1: Number of New Hampshire Resident Child Deaths by Cause, 2016-2020 and 2020

Cause of Death	2016-2020		2020	
	Number	Percent	Number	Percent
Natural	336	52 %	71	56.3 %
Injury	295	45.7 %	54	42.9 %
Other / Unknown	15	2.3 %	1	0.8 %
Total	**646**	**100%**	**126**	**100%**

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020.

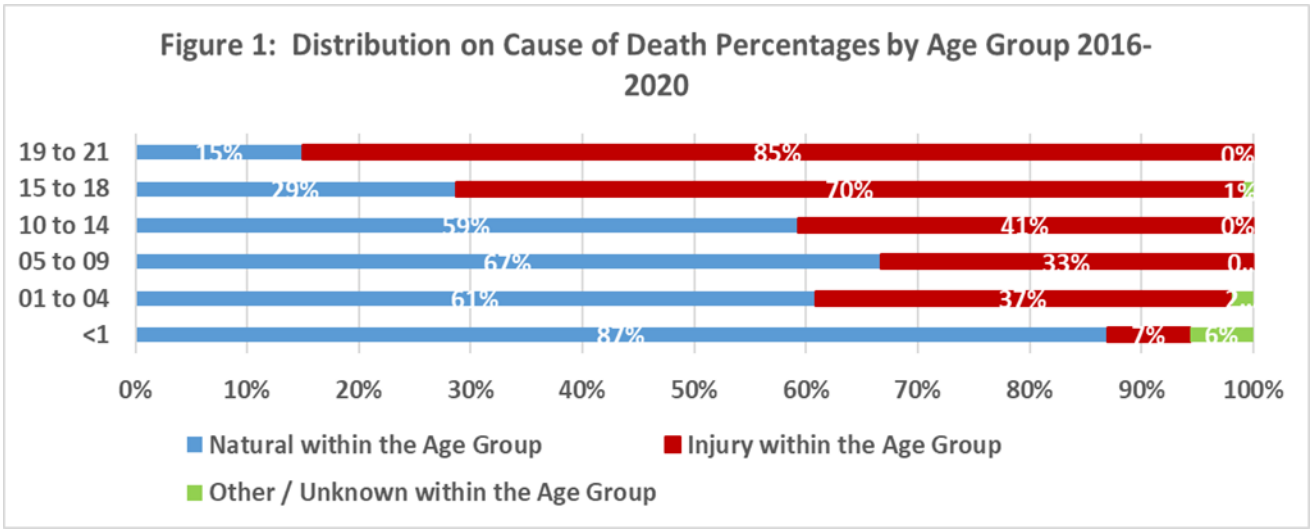
The first year of life continues to be the most perilous for New Hampshire children, accounting for 35.4 % of all deaths among children under the age of 21 from 2016-2020 (Table 2). Young adults aged 19 to 21 years represented the next highest percentages of deaths at 27.9 % (Table 2).

Table 2: Number of New Hampshire Resident Child Deaths by Cause and Age Group, 2016-2020

Age Group	Accidental	Homicide	Natural	Pending	Suicide	Undetermined	Total	Percent by Age group
<1	5	3	199	1		21	229	35.4%
01 to 04	12	5	31			3	51	7.9%
05 to 09	5	2	16			1	24	3.7%
10 to 14	8		32		12	2	54	8.4%
15 to 18	38	2	31	1	35	1	108	16.7%
19 to 21	96	4	27		50	3	180	27.9%
Total	164	16	336	2	97	31	646	100.0%

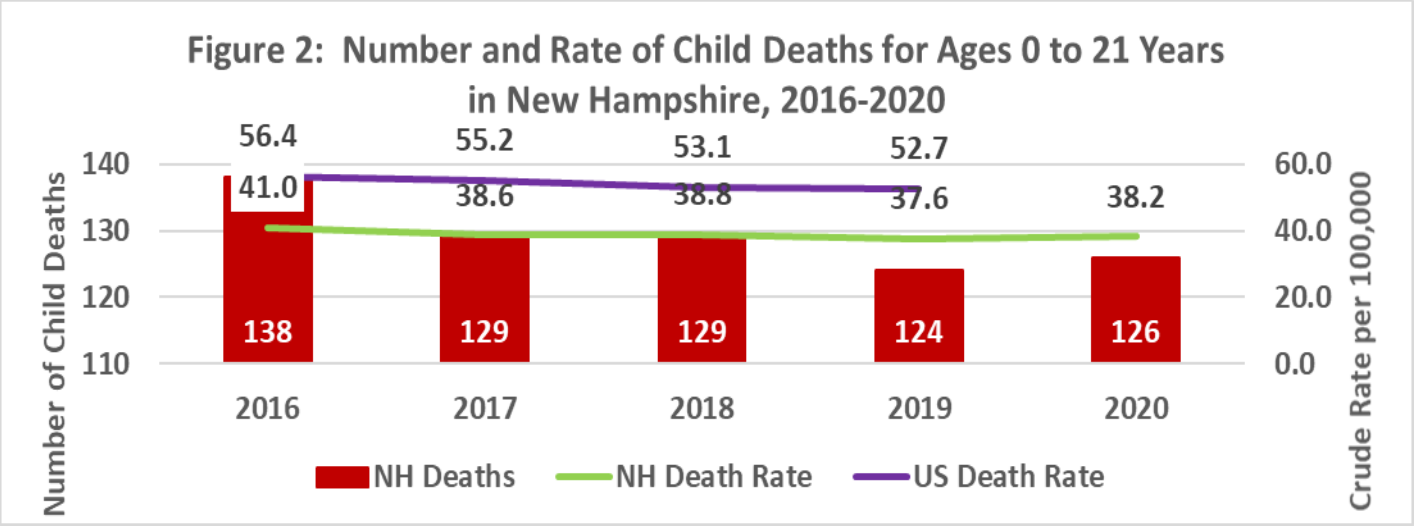
Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020.

The majority of deaths in infants under age one were due to natural causes (87%, Figure 1). Conversely, for young adults 19-21, injury accounted for the majority deaths (85 %, Figure 1).



Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020.

The 2020 child mortality rate for New Hampshire was 38.2 child deaths per 100,000 children (0-21 years of age). The rate did not change significantly compared to the 2019 rate of 37.6 per 100,000 children. New Hampshire's child mortality rate (37.6) continues to be below the national rate (52.7). Figure 2 shows the number and rate of child deaths in New Hampshire and the U.S. between 2016 and 2020. The US crude rate is not available for 2020.



Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020. National Rates: CDC Wonder

Infant Death Data Review

Infants less than one year of age died primarily from natural causes. More specifically, the most common cause of deaths in the aggregated five-year time period (Table 3) was "certain conditions originating in the perinatal period," including certain maternal factors and by complications of pregnancy, labor and delivery. This category made up 39% of all natural deaths.

Table 3: New Hampshire Residents, Top Five Leading Causes of Natural Deaths, Infants (under age 1 year), 2016-2020

Leading Causes of Infant Death	2016-2020	Percent of Total Cases
Certain conditions originating in the perinatal period	78	39%
Diseases of the respiratory system	48	24%
Congenital malformations ,deformations and chromosomal abnormalities	26	13%
Diseases of the circulatory system	20	10%
Sudden Infant Death Syndrome (SIDS)	11	6%
Other disorders originating in the perinatal period	7	4%
All Other Natural Causes of Death	9	4%
Grand Total	**199**	100 %

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020

Sudden Unexpected Infant Death (SUID) Review

The RSA132:41 placed the Sudden Unexplained Infant Death (SUID) and the Sudden Death in Youth (SDY) committees as sub-committees under the CFRC with the same protections and responsibilities. New Hampshire is one of twelve states receiving a grant from the CDC to participate in a Sudden Unexpected Infant Death (SUID) Case Registry to monitor SUID trends and characteristics that may affect the risk of SUID, such as infant sleep position. Monitoring SUID rates is vital to identifying new risk factors and tracking progress toward reducing infant deaths. Reviews improve the quality and consistency of SUID investigation data, which helps states develop informed prevention activities.

The SUID Committee reviews SUID category deaths that includes deaths due to Sudden Infant Death Syndrome (SIDS) and accidental suffocation and strangulation in bed (ICD10 codes: R95=SIDS and W75=Suffocation). Undetermined deaths (ICD10 code R99), under one year old can be grouped and counted in the category of "Sudden Unexpected Infant Death" and are reviewed by the SUID committee. From 2016-2020, New Hampshire had 37 SUID cases and all of these cases were reviewed by SUID Committee (Table 4).

Table 4: New Hampshire Residents, SUID Death Counts by Year, 2016-2020

Cause of Death	2016	2017	2018	2019	2020	Total
SUID (ICD10 Code: R95, R99, & W75)	8	7	8	5	9	37

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020 (Counts reflect the result of the reviewed and confirmed SUID cases)

Children, Adolescents, and Young Adult Deaths Review (Ages 1 to 21)

For children between one and 21 years of age, data are presented by cause of death and manner of death. In this age group, the leading cause of death is due to injury (intentional or unintentional). Natural causes of death accounted for 32.9 % of deaths, and malignant neoplasms (cancer) is the leading cause of natural deaths (Table 5).

Table 5: New Hampshire Residents, Leading Causes of Death, Ages 1 to 21, 2016-2020

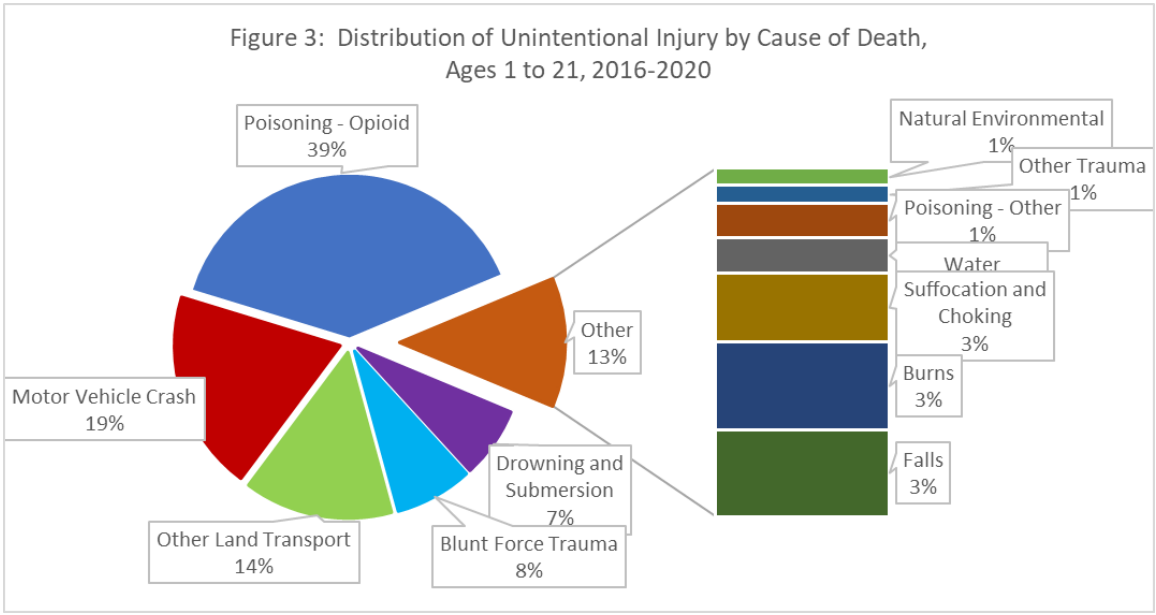
Cause of Death	Counts	Percentage
Natural	137	32.9 %
Intentional	110	26.4 %
Unintentional	159	38.1 %
Undetermined	11	2.6 %

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020

Unintentional Injury Deaths (Ages 1 to 21)

The top five causes of unintentional injury death among children and youth ages 1 to 21 (Figure 3) are: poisoning deaths due to opioids (39%); motor vehicle accidents (19%); other land transport accidents (ATVs, snow mobile related accidents; 14 %); blunt force trauma (8 %), and drowning and submersion (7%).

Figure 3: Distribution of Unintentional Injury by Cause of Death, Ages 1 to 21, 2016-2020



Poisoning deaths due to opioids accounted for the highest rate (39%) of all unintentional deaths among children and youth ages 1 to 21. Motor vehicle accidents was the second most common cause at (19.5%) with other land transport accidents being the third most common cause (14.5 %).

Table 6: New Hampshire Residents, Types of Unintentional (Accidental) Injury Deaths, Ages 1-21, 2016-2020

Accidental Causes of Death	01 to 04	05 to 09	10 to 14	15 to 18	19 to 21	Total	Total %
Poisoning - Opioid	1		1	6	54	62	39.0%
Motor Vehicle Accidents	2	2		9	18	31	19.5%
Other Land Transport			3	10	10	23	14.5%
Blunt Force Trauma	1			3	8	12	7.5%
Drowning and Submersion	3	1	2	3	2	11	6.9%
Burns	3	1		1		5	3.1%
Falls	1		2	1	1	5	3.1%
Suffocation and Choking		1		3		4	2.5%
Poisoning - Other					2	2	1.3%
Water Transport				1	1	2	1.3%
Natural Environmental	1					1	0.6%
Other Trauma				1		1	0.6%
Total	12	5	8	38	96	159	100.0%

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020.

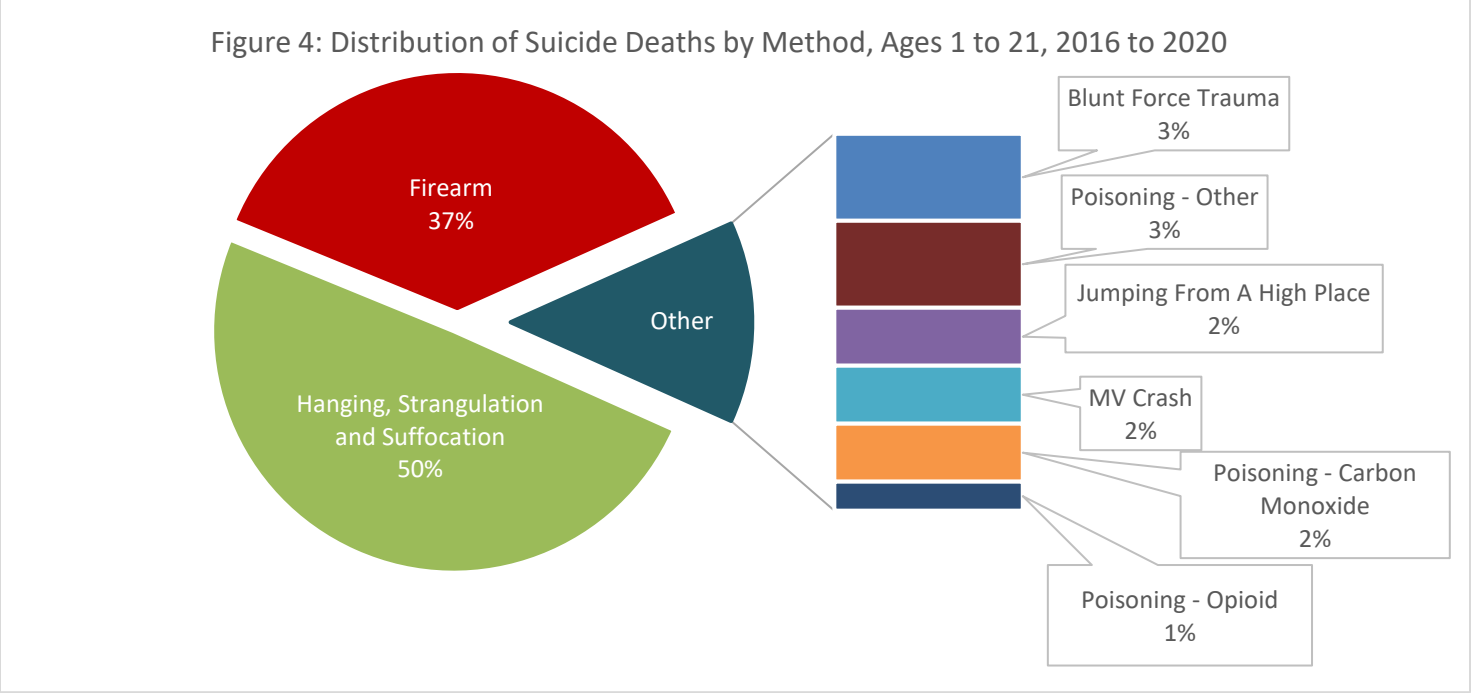
Intentional Injury Deaths (Ages 1 to 21)

Suicide (88%) is the leading cause of intentional injury deaths in children ages 1 to 21, and the incidence of suicide deaths is highest among youth ages 19 to 21 (Table 7). The method of death in half of the suicides is hanging/asphyxiation (50%), followed by firearms (37%), and poisoning (6%) (Figure 4).

Table 7: New Hampshire Residents, Intentional Injury Deaths, Ages 1 to 21, 2016-2020

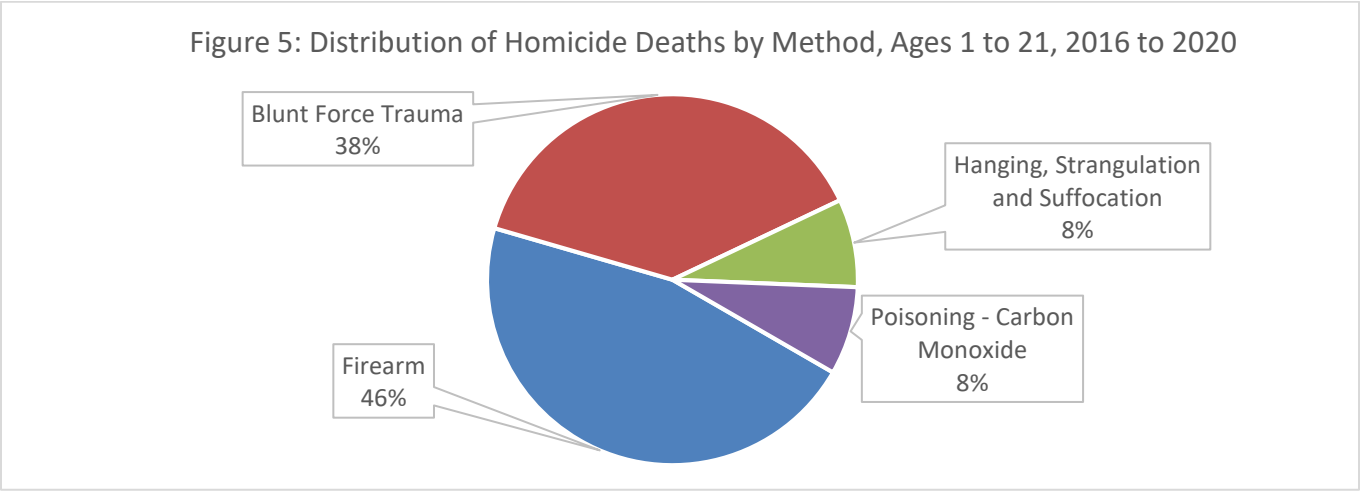
	01 to 04	05 to 09	10 to 14	15 to 18	19 to 21	Total	Total Percentage
Homicide	5	2		2	4	**13**	**12%**
Suicide			12	35	50	**97**	**88%**
Total	**5**	**2**	**12**	**37**	**54**	**110**	

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020



Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020

For more information about suicide, please refer to NH Suicide Prevention Annual Report 2020. This report is one of the most up to date resources available on suicide and suicidality in New Hampshire[1]. A new report is released each fall, summarizing data from the previous calendar year. The report is the collaborative work of many organizations in New Hampshire who have dedicated time and resources to study the issue of suicide in our state.



Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020

Among intentional injury deaths related to homicide, 46% were caused by firearms, and 38% by blunt force trauma.

Undetermined Deaths (Age 1 to 21)

Undetermined manner deaths are a category for deaths in which no manner of death can be discerned. Undetermined manner deaths are included as a separate category and should not be included when discussing injury deaths. Undetermined manner means that accidental or suicide/homicide intent could not be determined with the available evidence. These deaths are neither homicide nor suicide, and cannot be deemed an accident with the available evidence. Table 8 show the counts for undetermined manner deaths by age group.

Table 8: New Hampshire Residents, Undetermined Manner of Deaths, Ages 0 to 21, 2016-2020

	01 to 04	05 to 09	10 to 14	15 to 18	19 to 21	Total
Total	**3**	**1**	**2**	**2**	**3**	**11**

Data Source: New Hampshire Department of Health and Human Services, Injury Prevention Program. Death Certificate Data provided by the New Hampshire Department of State, Division of Vital Records Administration, 2016-2020.

CRFC Activities and 2021 Policy Recommendations

The CFRC focused on two types of deaths this past year, poisoning deaths related to opioids and motor vehicle accidents. During 2021 the Committee held six review meetings and reviewed eight cases, which included four drug related fatalities and four motor vehicle accidents. This report does not identify case specific risk and protective factors or objective findings, and does not discuss case specific Adverse Childhood Experiences (ACES). It is noteworthy that many deaths were among individuals with multiple ACES. This year the CFRC recommendations are not presented in a tiered fashion as the committee recognizes that they are all a priority in preventing child deaths in New Hampshire. The recommendations reflects the public health impact in improving the lives of children of New Hampshire and impact on improving the efficacy and efficiency of the agencies identified under recommendations.

Recommendation	**Responsible Party**
Understand the capacity, needs, authorities, and resources needed in order to review the full life course of the children whose deaths are under review	Department of Health and Human Services (DHHS)
Training on ACES for Various Sectors affecting the child's life, including schools and daycares	Schools and Early Childhood Programs - Department of Education (DOE) and DHHS. ACES Training for Judges and Lawyers- NH Court System and DHHS
Determine programs or processes that facilitate better communication among schools, primary care providers, and behavioral health providers	DHHS
Create a referral system for home visiting Services and other wraparound services when needed.	DHHS – Division of Public Health Services (DPHS), Division for Children Youth and Families (DCYF)
Explore pros and cons of additional restrictions related to a graduated driver's license for young people.	DHHS/DPHS will identify the RSA and explore the changes necessary to modify the requirements

Recommendation	Responsible Party
Explore the potential to modify the driver's education curriculum to include: Guidance for parents for: - **Safety in terms of maintenance** - **Types of cars that are safest** - **Winter preparation** The use of simulators to address situations and issues not encountered in training (e.g., winter driving) An increasing focus on impaired driving, including prescription medication, illicit drugs, and alcohol.	Injury Prevention Center
Improve the completeness of records around child fatalities from crashes, including identifying requirements for crash reconstruction when youth fatalities are involved.	Office of the Attorney General (AG)
Develop or renew campaigns to reinforce key messages: don’t drink and drive and the importance of having a designated driver.	DHHS and Governor's Commission on Alcohol and Other Drugs
Develop and educate yound people on how to react and what they can do if they don’t feel safe with others driving - both development of tools, if needed, and the education necessary to use them effectively; potentially leverage the "learn everywhere" mechanism to incentivize education on these issues.	Injury Prevention Center and Division of Behavioral Health (DBH)
Develop or renew campaigns to reinforce key messages: seatbelt use.	Injury Prevention Center

CFRC 2020 Policy Recommendations Progress

In 2020, CFRC recommendations were categorized as organizational development and policies to improve the function of the CFRC and those relating specifically to cases involving the death of a child in New Hampshire.

The operational recommendations to improve the effectiveness of the committee included items such as:

- Recommending the CFRC receive training and resources in several topics to help ground its work, such as the role of vicarious trauma and self-care for members and inclusion of the role of health equity in child fatality review. **Ongoing.**
- Recommending the creation of an orientation power point to onboard new members and their alternates. **Completed.**
- Recommending an invitation to the primary care provider of a child who has died to attend the meetings to share medical history and insights. **Ongoing.**
- Recommending the request for at least the most current three years of medical records to help inform the review. **Completed.**
- Recommending that the CFRC explore the feasibility of entering New Hampshire data into the National Child Fatality Review Data set. **On hold due to COVID-19 impacts.**

Implementation of these recommendations has begun and is helping guide the committee's future reviews. The information on meetings and other information about the committee is available at: https://www.dhhs.nh.gov/dphs/bchs/mch/cfrc/index.htm

The CFRC focused on two types of deaths in its 2020 report: suicides and drownings. The CFRC reviewed four suicide and three drowning cases. Below is the progress on the recommendations identified by the committee.

Recommendation	Responsible Party	Progress
Establish and interagency workgroup on feasibility of sharing child deaths data across the agencies.	Interagency Workgroup: Department of Health and Human Services (DHHS)-Division of Public Health Services (DPHS)/Division for Children Youth and Families (DCYF), Department of Education (DOE), Department of Safety (DOS), the Office of the Child Advocate (OCA), and Office of the Attorney General (OAG).	On hold

Recommendation	Responsible Party	Progress
Utilize the Know and Tell training available now for stakeholders to enhance awareness for ALL to report child abuse/neglect.	DCYF and Granite State Children's Alliance	Ongoing
Explore online decision-making tool for professionals/teachers/childcare/police to ensure reporting and encourage appropriate referrals to care.	DCYF and CFRC Co-Chair	Ongoing
When a child fatality occurs and where there is suspected abuse or neglect in NH, a referral may be made to the CAPP program by DCYF for record review and recommendations.	DCYF & Child Advocacy and Protection Program (CAPP)	Ongoing
Establish a legislative study committee to explore residential pool safety laws for NH.	DHHS	Due to COVID-19, this has been delayed and DHHS will be working with CFRC members to include this into the SFY 2022-2023 legislative session
Explore the use of the National Child Fatality Suicide Death Investigation Form.	Office of the Chief Medical Examiner’s Office (OCME) and CFRC Co-Chair	The OCME is using a new case management software system with a built-in form for the investigation of suicides, and will not be adopting this form.
Share the American Academy of Pediatrics (AAP) Drowning Prevention Tool kit and Pool safely/Safe Kids resources with the CFRC members and ask them to disseminate. Consider recommendations for child care	CFRC Co-Chair and Home Visiting Programs	Ongoing

Recommendation	Responsible Party	Progress
providers, home visiting, and parents/grandparents.		
Share AAP Drowning Prevention Tool kit and Pool safely/Safe Kids resources with Medical Providers. Recommend health care providers follow AAP Drowning Prevention Toolkit recommendations regarding promoting water competency / drowning prevention.	New Hampshire Pediatric Society and New Hampshire Medical Society	Ongoing
In the event a community or organization is exploring sponsoring or creating a Life Jacket Loaner Station in NH, they can reach out to NH Marine Patrol for support in obtaining child sized life jackets.	New Hampshire Marine Patrol	NH Marine Patrol is willing to work with any entity looking to equip a loaner station with child sized life jackets. This assistance may vary from year to year depending upon available grants. Assistance will include vendor identification, connecting with national non-profits as resources, and, at times, actual jacket donation.
Establish consistent mechanism to inform primary care providers (PCPs) of deaths.	DHHS/OCME	For pediatric deaths, the OCME requests medical records and performs an autopsy on all unexplained deaths (i.e. SUID/SDY) so these PCPs are automatically notified. Pediatric suicides and accidents, however, are evaluated on a case-by-case basis and may or may not receive an autopsy. Because there are

Recommendation	Responsible Party	Progress
		relatively few such deaths under age 18, the office staff is able to notify the PCP, if known, by phone after receiving the report from the investigator (typically within one week of death). The OCME does not have resources to extend this practice to patients over 18.
Recommend communities explore programs focused on reducing child abuse and maltreatment, such as the Community Collaborations to Strengthen and Preserve Families grant and Adverse Childhood Experiences Response Team (ACERT) Programs to increase referrals for children exposed to vicarious trauma.	DHHS /NH Charitable Foundation	On hold
Review resources sent to families after death of child. Explore "grief packets" issued by the State.	DHHS and Other State Agencies	The OCME and DPHS have been leading this effort
Explore feasibility of referral from animal control and police to DCYF if child is present during animal cruelty incident.	Office of the Child Advocate (OCA)/DCYF	The OCA and DCYF a support promoting the idea to include this in the Know and Tell curriculum and working to include this into the DCYF-Law Enforcement investigation protocols when they are refined.
Add questions regarding water competency training when doing death scene investigation.	OCME	For drowning deaths, the OCME routinely inquire about swimming ability and water safety devices. In addition, OCME new case management system has a specific

Recommendation	Responsible Party	Progress
		built-in form for the investigation of drowning deaths.
Explore asking the Commissioners of the Departments of Safety and Natural and Cultural Resources to convene a work group to continue to identify hazardous swimming sites in NH and create signage and GPS locations to assist in responding to swimming emergencies.	NH CFRC Executive Committee/ DOS/Fish and Game/DNCR/911	While not a formal working group, these agencies have worked together to identify locations where swimming emergencies have occurred multiple times. A resource document has been generated along with signage for these locations. In addition, the Department of Safety-Marine Patrol worked with NH Correctional Industries (State Prison Sign Shop) on the creation of a sign that any entity can purchase for posting at areas of concern.
Notify the Food and Drug Administration if a death occurs during use of medications that include a black box warning related to death.	TBD	On hold
Recommend that all healthcare organizations review unanticipated deaths of their pediatric patients, especially those that die by suicide.	New Hampshire Medical Society	On hold
Recommend that all primary care practices establish a policy/protocol to address missed appointments of patients.	New Hampshire Medical Society	On hold
Explore Epping Police policy regarding following up with families when notified of DCYF involvement. Determine if this	DCYF awaiting rollout of the newest addition of protocols from the Attorney General's office and will be basing their	

Recommendation	Responsible Party	Progress
is a best practice and should be shared with other departments. At the Request on DCYF, this recommendation will be followed up on in the future.	best practice models on these directives.	

Sudden Unexpected Infant Death (SUID) and Sudden Death in Young (SDY) Review Committees, Activities, and Recommendations 2021

The SUID and SDY Review Committees use New Hampshire data to increase the understanding of the prevalence, causes, and risk factors for infants, children, and young adults who die suddenly and unexpectedly. In 2021, the SUID and SDY Committees met six times, and have scheduled all SUID and SDY case reviews for 2022.

In 2021, the SUID/SDY program made significant progress with the Safe Sleep workgroup on developing a campaign for community awareness. The Safe Sleep workgroup has meet four times, and uses the recommendations from the SUID case reviews to identify target populations on which to focus education efforts. The target populations are providers, parents and caregivers who co-sleep with their infants, and general awareness for the public. One strategy that the Safe Sleep work group developed was to hold four town hall-style Zoom meetings in 2022. The goal of these meetings is to engage the target populations and provide educational materials and information about safe sleep. The Safe Sleep workgroup will continue to meet quarterly and focus on how to implement the recommendations based on the case reviews. The SUID/SDY Program Coordinator is working on recruiting other professionals in the communities such as, home visitors, and other community health programs who are visiting the families in their home to strengthen the Safe Sleep workgroup activities.

The SUID/SDY Program is collaborating with the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program to increase the number of infants enrolled in Healthy Families America (HFA)-NH home visiting, who are always placed on their backs to sleep. The SUID/SDY Program and the MIECHV Program will be working with a HFA Local Implementing Agency (LIA) to increase service provider awareness, accurate data reporting, and education on safe sleep. After collaborating with this LIA, the SUID/SDY Program and the MIECHV Program will use the successes and lesson learned during this collaboration to disseminate to the other LIAs in the HFA-NH program.

The SUID/SDY program continues to provide safe sleep information through social media. The program posts safe sleep messaging on the DPHS social media pages. During the month of October, the project coordinator posted a series of safe sleep messages on social media to raise awareness in honor of SIDS Awareness Month. The SUID/SDY Program Coordinator is scheduled to meet with new parent support groups in 2022. During these meetings, the Program Coordinator will educate new parents and caregivers on safe sleep practices, and provide educational materials to support these families on how to practice safe sleep. The SUID/SDY program continues to provide safe sleep materials to family resource centers, birthing hospitals, and other community health programs. These safe sleep materials include information targeted to parents, caregivers, and providers on how to practice safe sleep. The SUID/SDY is collaborating with a local birthing hospital to speak with expecting families to promote safe sleep and provide an opportunity for new parents to discuss safe sleep practices.

The membership for these two committee is included in appendices D (SUID Committee) and E (SDY Committee).

Appendix A: Child Fatality Review Committee Membership

Members January 2021- December 2021

Honorable Susan Ashley
NH Circuit Court- Family Division

Joy Barrett
Granite State Children's Alliance

Skip Berrien
Member of the Public

Vicki Blanchard*
Bureau of Emergency Medical Services

Christine Brennan
Department of Education

Steven Chapman
Pediatrics- Dartmouth-Hitchcock

Dianne Chase
Bureau of Child Development

Marc Clement*#
Colby-Sawyer College

Anne Diefendorf
New Hampshire Hospital Association

Jennie Duval*
Chief Medical Examiner

Adam Fanjoy
New Hampshire Fire Marshal's Office

Katja FoxDirector, Division of Behavioral Health,
Department of Health and Human Services

Marti Ilg, Deputy Director
Division of Economic Housing Stability,
Department of Health and Human Services

Ann Landry*
Associate Commissioner, Department of Health & Human Services

Moira O'Neill
Office of the Child Advocate

Resmiye Oral
DHMC Child Advocacy and Protection Program or designee

Child Advocacy & Protection Program
Dartmouth-Hitchcock

David Parenteau
Statewide Law Enforcement Officers' Advisory Council

Sylvia Pelletier
New Hampshire Family Voices

Stacie Moeser*
Office of the Attorney General

James Potter
New Hampshire Pediatric Society

Josephine Porter*#
Epidemiologist- UNH

Joseph Ribsam*
Director, Division for Children, Youth, and Families, Department of Health and Human Services

Schelley Rondeau
Home Visiting Program

Angie Raymond-Leduc
Injury Prevention Center- Dartmouth-Hitchcock

Rhonda Siegel*
Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services

Marcia Sink
Court Appointed Special Advocates (CASA) of New Hampshire

Lissa Sirois
Women, Infants, and Children Nutrition Services, Division of Public Health Services, Department of Health and Human Services

Catherine Shackford
New Hampshire State Police

Joi Smith
NH Coalition Against Domestic & Sexual Violence

* = Executive Committee Member
# = Co-Chair of the Committee

Appendix B: SUID Review Group Membership

Dierdra Batchelder
Office of the Chief Medical Examiner-SUID and SDY data analyst

Vicki Blanchard
Department of Safety, EMS

Karl Boisvert
Quality Assurance and Improvements, Department of Health and Human Services

Charles Cappetta
DHMC, Pediatrician

Anne Diefendorf
New Hampshire Hospital Association
**Anne retired in Oct. 2021-Kris Hering will be replacing Anne.*

Jennie Duval
Office of Chief Medical Examiner

Sherry Ermel
Bureau Chief of Field Services, Division for Children, Youth and Families, Department of Health and Human Services

Kim Fallon
Office of the Chief Medical Examiner/Chief Forensic Investigator

Elizabeth Fenner-Lukaitis
Bureau of Behavioral Health, Department of Health and Human Services

Victoria Flanagan
DHMC, perinatal outreach educator, Director of Operations, NNEPQIN

Anne Frechette
Association of Women's Health, Obstetric and Neonatal Nurse (AHWONN) Representative

Sarah Goss
DHHS, SUID/SDY Program, Division of Public Health Services, Department of Health and Human Services

James Gray
DHMC, Neonatologist

Kristi Hart
DHHS Home Visiting, Division of Public Health Services, Department of Health and Human Services

Courtney Keane
MCH Infant Program Manager Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services

JoAnne Miles-Holmes
Injury Prevention, Division of Public Health Services, Department of Health and Human Services

Paula Oliveira
New Hampshire Breastfeeding Association

Linda Parker
Bureau of Behavioral Health, Department of Health and Human Services

Josephine Porter
Co-Chair Child Fatality Review Committee

Kristiane Schott
Division of Economic and Housing Stability, Department of Health and Human Services

Jonelle Gaffney
CASA NH

Rhonda Siegel
Administrator, Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services

Lissa Sirois
Women, Infants, and Children Nutrition Services, Division of Public Health Services, Department of Health and Human Services

Sherry Stevens
Certified Professional Midwife

Appendix C: SDY Review Group Membership

Dierdra Batchelder
Office of the Chief Medical Examiner-SUID and SDY data analyst or designee

Vicki Blanchard
EMS or designee

Marc Clement
Child Psychologist, Co-Chair Child Fatality Review Committee

David Crowley MD
Pediatric Cardiologist or designee

Anne Diefendorf
New Hampshire Hospital Association or designee
**Anne retired in Oct. 2021-Kris Hering will be replacing Anne.*

Mary Beth Dinulos
Pediatrician/Pediatric Geneticist or designee

Deirdre Dunn
Special Medical Services or designee

Jennie Duval
Office of Chief Medical Examiner or designee

Emily Knight
Intensive Care Pediatric Nurse or designee

Kim Fallon
Office of the Chief Medical Examiner/Chief Forensic Investigator or designee

Elizabeth Fenner-Lukaitis
Bureau of Behavioral Health, Department of Health and Human Services or designee

Jonelle Gaffney
CASA NH or designee

Sarah Goss
DHHS, SUID/SDY Program, Division of Public Health Services, Department of Health and Human Services

Michele Guertin
Child Care Licensing, Department of Health and Human Services or designee

Courtney Keane
Infant Program Manager, Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services

Kristin Kraunnelis
Pediatric Mental Health Nurse or designee

Susan Moore
Nurse/Special Medical Services or designee

Richard Morse
Pediatric Neurologist or designee

Sylvia Pelletier
New Hampshire Family Voices or designee

Kristiane Schott
Bureau of Housing and Economic Supports, Division of Economic and Housing Stability or designee

Rhonda Siegel , Administrator
Maternal and Child Health, Division of Public Health Services, Department of Health and Human Services or designee

Lissa Sirois
Women, Infants, and Children Nutrition Services, Division of Public Health Services, Department of Health and Human Services

Sherry Stevens
Certified Professional Midwife or designee